

State Model

CHILD ABUSE PROTOCOL

Introduction

19-15-2. *Each county shall be required to establish a child abuse protocol.*

The State Model Child Abuse Protocol has been created by the Georgia Child Fatality Review Panel in collaboration with the Office of the Child Advocate, The Special Investigations Unit, the Georgia Bureau of Investigations and county child abuse protocols as an instrument to **assist** counties with best practices towards creating efforts by all mandated agencies to investigate, treat and manage cases of child abuse and neglect.

County Child Abuse Protocol committees should evaluate resources by all agencies involved and evaluate the needs of the community *prior* to implementing this protocol. The model protocol can be incorporated entirely or can be applied only to those areas that are feasible for the community. *Please note that any areas that are incorporated into the county local protocol should be implemented.*

Brackets have been placed within the document around areas that require county specific information.

Again, this is a **MODEL**, not a requirement, however the model protocol is strongly encouraged for counties to apply. Several procedures from the model protocol have been successfully used throughout the state by creating cohesive agency cooperation and an immediate and thorough response towards child abuse and neglect.

If you need further assistance concerning the model protocol, please call the **Georgia Child Fatality Review Panel at 770-528-3988**.

TABLE OF CONTENTS

	PAGE
PREFACE	
History.....	4
Mission	4
Membership	4
Preamble	5
Confidentiality Statement.....	5
REPORTING PROCEDURES	
Georgia Code Section 19-7-5.....	8
Dept. of Family & Children’s Services.....	9
Law Enforcement	
Child Abuse Referrals.....	10
Working Jointly with DFCS	10
Staffing Referrals with DFCS.....	11
Medical Personnel	
Sexual Abuse.....	12
Physical Abuse.....	13
Neglect.....	13
Munchausen by Proxy	14
County Public Health	15
Schools.....	16
Children Expressing Suicidal Ideations	17
Department of Juvenile Justice	18
Mental Health Services	19
INVESTIGATIVE PROCEDURES	
DFCS	21
Investigation of Accepted Reports	21
Interviewing Children at School	21
Investigative Reports.....	21
Investigations Involving Substance Abusing Mothers and Newborn Infants	23
Law Enforcement	24
Basic Investigation	24
Joint Investigation.....	25
Sexual Abuse Forensic Interview Process	26
Joint Investigation.....	26
Forensic Interview Procedures	26
The Child Advocacy Center.....	27
Forensic Evaluation Procedures.....	28

JUDICIAL PROCEDURES

Juvenile Court Proceedings..... 31
C.A.S.A..... 33
Magistrate Court Procedures..... 35
Superior Court Procedures..... 36
Victim Protection 37

TREATMENT

Treatment Format for Child Abuse Cases..... 39

TRAINING

Neglect and Maltreatment 41
Physical Abuse..... 42
Munchausen By Proxy..... 43
Sexual Abuse..... 45
Emotional/ Verbal Abuse 46

PREVENTION 49

ENSURING COMPLIANCE

Participation 51
Annual Report..... 51

APPENDIX A

Legal requirement to Report Abuse 53

APPENDIX B

Child Fatality Review 56

APPENDIX C

Emergency Custody by a Physician..... 61

PREFACE

PREFACE

History

{We recommend that counties include their history of operation/ implementation as it relates to the child abuse protocol}

Mission

The mission of the Child Abuse Protocol is the following:

- a. To write, review and establish the protocol document, outlining in detail the procedures to be used in investigating and prosecuting cases arising from alleged child abuse and the methods to be used in coordinating treatment programs for the perpetrator, the family, and the child.
- b. To coordinate the efforts of all agencies, which investigate, treat and manage cases of child abuse and neglect.
- c. To investigate and review cases of unexplained child fatalities.
- d. To facilitate and support agencies, organizations and individuals whose efforts are directed towards abuse prevention.

To accomplish this mission, the Protocol Committee meets regularly to ensure coordination and cooperation of the various agencies, organizations and individuals, as they work with cases of abuse in the course of their duties. The Protocol Committee strives to increase the efficiency of the member agencies as well as to minimize the stress to the child victim of abuse, which can be created by the legal and investigatory process. Additionally, the Protocol Committee functions in an oversight capacity to ensure that more effective treatment is provided for the perpetrator, the victim and the family. The effectiveness of the Protocol itself is monitored and revised as necessary and goals are established on a yearly basis.

Membership

The current Protocol Committee consists of representatives of the following agencies whose membership is required by O.C.G.A. § 19-15-2:

- a. The office of the sheriff;**
- b. The county department of family and children's services;**
- c. The office of the district attorney;**
- d. The juvenile court;**
- e. The magistrate court;**
- f. The county board of education;**
- g. The county mental health organization;**

- h. The office of the chief of police of the county policy department**
- i. The office of the chief of police of the largest municipality in the county;**
- j. The county board of health, which shall designate a physician**
- k. The office of the coroner or county medical examiner.**

In addition, the law requires that the committee shall have a member who represents a local citizen or advocacy group, which focuses on child abuse awareness and prevention.

The membership of the _____ County Child Abuse Protocol Committee satisfies these statutory requirements and includes other members selected by the Protocol Committee for their expertise in related fields of medicine, advocacy and management. These members include: Pediatrician, Child Advocate, etc.

Preamble

The purpose of the Child Abuse Protocol is to protect children who have been, or are alleged to have been abused by insuring that the needs of the child are given priority over system or agency needs. As such, the recommendations of the Child Abuse Protocol are not intended to preclude agencies policies and procedures. While the failure to follow protocol indicates an action that potentially may cause harm to a child, such a failure does not necessitate the conclusion that the actions are somehow legally flawed.

Confidentiality

The meetings and proceedings of a committee or subcommittee of the Child Abuse Protocol in the exercise of its duties shall be closed to the public and shall not be subject to open meetings.

Records and other documents, which are made public records pursuant to any other provisions of law, shall remain public records notwithstanding their being obtained, considered, or both, by a committee, a subcommittee, or the panel.

Members of the Child Abuse Protocol Committee shall not disclose what transpires at any meeting nor disclose any information the disclosure of which is prohibited by O.C.G.A. § 19-15-6, except to carry out the purposes of this chapter.

A person who presents information to the Child Abuse Protocol Committee who is a member of any such body shall not be questioned in any civil or criminal proceeding regarding such presentation or regarding opinions formed by or confidential information obtained by such person as a result of serving as a member of any such body. However, such a person shall not be prohibited from testifying regarding information obtained independently of the committee or subcommittee. In any proceeding in which testimony of such a member is offered, the court shall first determine the source of such witness's knowledge.

Except as otherwise provided, information acquired by and records of the Child Abuse Protocol Committee shall be confidential, shall not be disclosed, and

shall not be subject to Article 4 of Chapter 18 of Title 50 of the official code relating to open records, or subject to subpoena, discovery, or introduction into evidence in any civil or criminal proceeding.

Pursuant to law, a member of the Child Abuse Protocol Committee shall not be civilly or criminally liable for any disclosure of information made by such member as authorized by this section.

Notwithstanding any other provisions of law, information acquired by and documents, records, and reports of the child abuse protocol committees and subcommittees applicable to a child who at the time of his or her death was in the custody of a state department or agency or foster parent shall not be confidential and shall be subject to Article 4 of Chapter 18 of Title 50, relating to open records.

While it is understood that MHDDAD providers make reports of abuse and may have records that are appropriate to share with other care providers, there is a limit to what MHDDAD should appropriately share. Additionally, when MHDDAD information is shared, it should be protected from further disclosure except as authorized by law.

The _____ County Child Abuse Protocol is not a confidential record of this Committee or its subcommittees and as such shall be considered public record. Copies of the Child Abuse Protocol may be distributed by the Protocol Committee upon payment of the costs of said copy or copies as provided by the Open Records Act.

REPORTING PROCEDURES

PROCEDURE FOR REPORTING CHILD ABUSE

O.C.G.A. § 19-7-5 states “An oral report shall be made as soon as possible by telephone or otherwise and followed by a report in writing, if requested, to a child welfare agency providing protective services, as designated by the Department of Human Resources, or, in the absence of such agency, to an appropriate police authority or district attorney. If a report of child abuse is made to the child welfare agency or independently discovered by the agency, and the agency has reasonable cause to believe such report is true, or the report contains any allegations or evidence of child abuse, then the agency shall immediately notify the appropriate police authority or district attorney”.

Reporting procedures need to include:

- The telephone number that must be called when reporting abuse and/ or neglect
- *{A template for a written report needs to be provided as an appendix to this manual}*

Please refer to Appendix A for further information regarding the legal requirement to report abuse as well as definitions as defined by O.C.G.A. § 19-7-5.

DEPARTMENT OF FAMILY & CHILDREN'S SERVICES (DFCS)

{County DFCS address and phone number}

- Reports assigned for investigation will be given a response time of either immediate to 24 hours or 5 working days. The seriousness of the allegations in the report and the urgency of the safety needs of the child determine response times.
- The 5 day response time for non-emergency reports is set as a minimal standard and should be responded to sooner whenever possible. In cases such as these, the DFCS investigator will proceed to conduct interviews as previously outlined and determine whether maltreatment has occurred and to what extent the child(ren) remain at risk.
- If at any time the DFCS investigator discovers the child is in immediate danger or there is evidence that a criminal act may have occurred, the investigator will immediately call the law enforcement agency having jurisdiction and request assistance.
- Should the DFCS investigator and supervisor determine that the child(ren) must be removed from the home in order to meet the safety needs, this can be accomplished in two ways:
 1. DFCS may request the assistance of law enforcement who has the authority to take immediate action in taking a child into protective custody.
 2. DFCS may contact their Special Assistant Attorney General (SAAG) and seek from the Juvenile Court an emergency order for shelter care signed by a Judge or an authorization for shelter care signed by a Juvenile Court Intake Officer granting DFCS immediate temporary custody until a hearing is convened within 72 hours.
- All incidents of child death, serious injury of children with open social service cases, and any other alleged incident of abuse or neglect in foster homes will be referred by the local DFCS to the DFCS Special Investigation Unit. In potentially high profile cases, the local DFCS may refer the matter to the DFCS Special Investigation Unit to avoid any appearance of a conflict of interest.
- After Hours *{After hours procedures should be established by each committee and developed into the protocol}*

LAW ENFORCEMENT

A. Law Enforcement and Child Abuse Referrals

- Determine if the allegation of sexual abuse, physical abuse, emotional abuse or neglect is founded by probable cause, and if the crime occurred in the jurisdiction of the agency.
- Child abuse cases will be handled in a priority manner depending on the severity of the abuse being referred.
- Law enforcement will initiate an investigation within 24 hours for children who are at imminent risk and within five days on all other referrals.
- Law enforcement will be familiar with the "Child Abuse Protocol" and make every attempt to follow the protocol to the best of their department's ability.
- Law enforcement will have at least one officer with advanced training in the area of child abuse investigation. This officer should be used as a reference source for all the officers in the agency, and should assist with the more severe cases of child abuse, which are reported to their agency, if necessary.
- When law enforcement receives a referral of child abuse from any source other than DFCS, a report will be filed with that police agency. Law enforcement will also notify DFCS.
- If the abuse occurred in the child's home or in a caretaker situation, then DFCS will be notified immediately.

B. Law enforcement agrees to work jointly with DFCS in the following situations:

- Any form of sexual abuse involving a child.
- Any form of physical assault by a parent, stepparent or other caretaker, which causes bruises.
- Any child under the age of three with any sign of abuse.
- Any fracture, broken bone, or burn on any child where physical abuse is suspected.
- Any severe neglect case where DFCS requests assistance.
- Any case where a family refuses to allow a DFCS worker to see the child victim in any abuse or neglect referral.
- The presence of any serious injury on a child for which the explanation offered is inadequate to explain the injury.
- Any case of physical abuse where there have been previous confirmed reports by DFCS.
- Any abuse referral diagnosed by a physician.
- Any form of Munchausen by Proxy/ Pediatric Condition Falsification and Factitious Disorder by Proxy.
- Any case involving the suspicious death of a child

It is important to note that although law enforcement agrees to work jointly with DFCS on the above mentioned incidents, the critical role for each agency is to have the ability to differentiate unintentional, circumstantial, or isolated incidents of maltreatment from deliberate, cruel or repeated maltreatment which may or may not involve law enforcement being actively involved.

C. Law Enforcement Staffing Referrals with DFCS

- Law enforcement receives referrals daily from DFCS either by phone, personal pickup, or by facsimile.
- Law enforcement will meet with DFCS Child Protective Unit weekly to staff referrals, unless more pressing case obligations arise that would take priority.
- Law enforcement will check their local files and criminal histories of suspects whenever possible prior to making a decision on the disposition of a referral.
- Law enforcement will notify DFCS if their records contain a past history of child abuse, domestic violence or physical assaults, and a joint decision should be made on how law enforcement will assist.
- Law enforcement will make inquiry of the DFCS investigator assigned to the referral of what action was taken by their Department.
- Law enforcement, DFCS investigator and supervisors will determine at that time if law enforcement assistance is necessary.

MEDICAL PERSONNEL

Medical personnel should respond to suspected abuse and neglect cases as outlined below. Please refer to Appendix B for further information regarding the legal requirement for a physician to take emergency custody of a child.

A. Sexual Abuse:

1. Recent Sexual Contact (within 72 hours)
 - Acute medical problems are identified and managed.
 - If child presents to the Emergency Room, a medical screening is completed to identify possible sexual contact (information is taken only as necessary for medical treatment).
 - Notify DFCS and law enforcement.
 - A formal forensic evaluation will be conducted at appropriate location.
 - Testing and treatment for sexually transmitted diseases and pregnancy is done as deemed necessary.
 - Follow-up appointment is made per DFCS or patient, and information from the Emergency Room or Child Advocacy Center / designated equipped location's record is made available to follow-up physician.
 - Written report is sent to DFCS and law enforcement with expert medical opinion clearly stated. Forensic interviews to occur at the Child Advocacy Center or designated equipped location (for children 14 years or younger) according to Protocol guidelines.

2. Sexual Abuse at remote time (> 72 hours)
 - Medical interview is done to confirm sexual contact (detailed questioning to be reserved for investigative interview).
 - Acute medical problems are evaluated and treated.
 - Notify DFCS.
 - Referral for medical evaluation is made per DFCS.
 - Copy of Emergency Room evaluation is sent to follow-up physician.

3. Medical condition suspicious for sexual abuse (bleeding or infection)
 - Thorough physical and laboratory examination of the patient is done (Rape Kit is done as deemed necessary).
 - Injuries and/or illness is treated.
 - Notify DFCS.
 - Copy of Emergency Room Report is sent to follow-up physician.
 - Written report is sent to DFCS, expert medical opinion clearly stated on report.

B. Physical Abuse:

1. Under the Age of 2 years

- A thorough history of the injury is taken separately from each person with the child.
- If the history is of abusive treatment or the injury does not match the history, the diagnosis of suspected child abuse is made and DFCS is notified.
- Written documentation of injuries is done.
- Photography is done. (*Photography is necessary. Equipment should be purchased by the team*)
- X-ray (skeletal survey) is done and laboratory tests are ordered as indicated.
- Medical care given as necessary.
- Copy of emergency record is sent to the follow up physician.
- Primary Care Physician or the Pediatrician on call is consulted. If available, a child abuse expert pediatrician is preferred
- Written report is sent to DFCS, with expert medical opinion clearly stated on the report.
- Examination of siblings is arranged by DFCS.

2. Over the age of 2 years

- History of the injury is taken separately from the child and each person who is with the child.
- If the history is of abusive treatment or the injury does not match the history, the diagnosis of suspected child abuse is made and DFCS is notified.
- Written documentation of injuries is done.
- Primary Care Physician or the Pediatrician on call is consulted if deemed necessary. If available, a child abuse expert pediatrician is preferred.
- Photography is done. (*Photography is necessary. Equipment should be purchased by the team*)
- X-ray (skeletal survey) is done and laboratory tests are ordered as indicated.
- Medical care given as necessary.
- Copy of emergency record is sent to the follow up physician.
- Written report is sent to DFCS, with expert medical opinion clearly stated.
- Examination of siblings is arranged by DFCS.

C. Neglect:

1. Failure to thrive

- Complete history and physical is done.
- Review of old medical records is done.
- Notify DFCS.
- If there is no consistent medical care provider, then a follow-up appointment is made by DFCS.

- Follow-up physician does examination of siblings.
 - Short and long-term treatment plan is developed.
2. Other Neglect issues and older children
- Complete medical history and physical is done.
 - Review of old medical records is done.
 - Notify DFCS.
 - Medical follow-up is arranged by DFCS.
3. Munchausen by Proxy (MSBP) / Pediatric Condition Falsification (PCF)
- PCF /MSBP is a medical diagnosis and can only be made by a licensed physician.
 - Intake reports made to any agency will be referred to the Multi Disciplinary Team for multidisciplinary intervention in coordination with medical personnel. A pediatric expert in PCF/MSBP should be consulted.
 - DFCS, medical personnel, and the MDT will consider whether notification of the parents poses a danger to the child. In general, routine notification of the parent that an investigation is in process is dangerous to the child until such time as the case is decided.
 - A plan of action for each agency represented will be coordinated through the MDT. A plan of action may include the following tasks:
 - Review all of child's available medical records
 - Obtain verification of as many items as possible (records of drugs purchased, blood levels on child)
 - Seek report of child's condition when parent is absent
 - If appropriate, video monitoring in hospital with plan in place to intervene if child is found to be in danger from perpetrator's actions
 - A plan of action may include the following tasks:
 - A. Follow-up protection plan by DFCS
 - B. Law Enforcement and legal actions as dictated by evidence

COUNTY PUBLIC HEALTH

{Address and Phone Number of Public Health Center}

If information exists to cause a staff member to reasonably believe that a child is a victim of abuse or neglect:

- The staff member shall make a report of abuse to DFCS.
- The incident as reported or observed shall be documented in the child's medical record.
- The child's attending physician shall be notified and advised of the incident.
- The report to protective services shall contain the following information: child's name, address, age, race, parent's names, care provider, children involved, as appropriate, and nature of the allegation.
- A copy of the written report shall be maintained in the child's record.
- The child's right to confidentiality should be respected. Information regarding diagnosis, current condition, and prognosis should be shared only as necessary in response to pertinent questions posed by protective services personnel. No release of information is required to make this report.
- The staff member should not verbally disclose to the parents/guardians or legal custodians of the child that a report is being made to protective services until the safety of the child has been established.
- When a report is made, a therapeutic approach shall always be utilized, presenting protective services as a "help" for families, not a punishment.
- Reports of suspected abuse and/or neglect made to appropriate protective services or police agencies in good faith render the reporter immune from civil or criminal liability.
- An incident report should be completed by a public health staff member for each suspected/actual incident of abuse.

_____ **COUNTY SCHOOLS**
CHILD ABUSE/NEGLECT REPORTING

{Address and Phone Number of School(s)}

- A. Classroom teacher or other school staff who suspects abuse should immediately notify the school counselor, Principal, or the appointed designee. Teachers are encouraged to document their suspicion of child abuse in writing as well as confirming with the appointed designee that a report was made.
- B. School Counselor or Principal should immediately cause a report to be made to the Department of Family and Children Services. Reports shall contain:
 - the names and addresses of the child and the parent/guardian, if known
 - the child's age
 - the nature and extent of suspected abuse/neglect
 - any other information that the Counselor or Principal believes would be helpful
- C. A brief report is to be sent to the Student Services Department at the Central Office by the Counselor.
- D. No employee shall contact a parent/guardian regarding the interview of their student in child abuse/neglect referrals.
- E. DFCS will be allowed to interview a child as necessary on school grounds. Every effort will be made to provide a private area for abuse investigations to be conducted. Counselor or Principal may be present during interviews.

CHILDREN EXPRESSING SUICIDAL IDEATIONS

Children experiencing acute thoughts of self-harm or suicide have become a growing concern. These concerns frequently come to light while the child is present at a school facility, having disclosed these feelings to a peer or school personnel. There may be many reasons and factors contributing to the child's thoughts or ideation of self-harm. Issues of child maltreatment by the child's parent/guardian may or may not be one of the issues immediately apparent. In order to deal with every such occurrence in a consistent and effective manner and to help the child safely through the immediate crisis, the following guidelines for intervention will be followed:

- The school principal or designee will be notified immediately by any school personnel who is aware that a child may have expressed thoughts or ideation of self-harm.
- The school principal, designee or school psychologist, where one is available, will be notified immediately to talk with the child in question.
- The school principal or designee will contact the child's parent/guardian and inform him/her of concerns regarding the child's thoughts of self-harm or suicide except in those instances where child maltreatment by the parent or care provider is suspected.
- The school principal or designee will immediately contact DFCS in those instances where parental or care provider maltreatment of the child is suspected or the parental response to the behavior is believed to be insufficient to see the child safely through the crisis.
- DFCS will initiate a Child Protective Services (CPS) investigation immediately on all reports from a school indicating a child is expressing suicidal thoughts or ideation and parental maltreatment is suspected or parental response is insufficient to meet the child's immediate safety needs.
- DFCS will immediately forward a copy of the report to the law enforcement agency having jurisdiction where the child resides.
- On all reports meeting the above criteria, DFCS will immediately contact _____ County Mental Health and request the assistance of a licensed therapist to make a joint visit to the school to assess the mental status and immediate risk to the child. DFCS and Mental Health should arrive at the school no later than 60 minutes from the time DFCS receives the referral.
- The Mental Health therapist will make the determination as to what interventions are required to address the child's immediate needs and ensure the child's safety.
- DFCS will determine what interventions are necessary to ensure the child's safety in reports that involve allegations of maltreatment.

DEPARTMENT OF JUVENILE JUSTICE

{Address and Phone Number}

When any employee believes or becomes aware of any suspected neglect, physical, emotional or sexual abuse of a child under the age of eighteen (18), that employee shall immediately report such neglect or abuse to the _____ County DFCS. The report shall contain the following:

- the names and addresses of the child and the parent/guardian, if known
- the child's date of birth
- the nature and extent of the suspected abuse/neglect
- any other information that the employee believes would be helpful

Should DFCS be closed for the day, then that employee shall report to law enforcement rather than wait for the next working day.

MENTAL HEALTH SERVICES

{Address and Phone Number}

If a child discloses sexual abuse or severe physical abuse during psychotherapy or counseling, the mental health provider should NOT attempt a forensic interview. The provider should not attempt to question the child in detail about the alleged abuse or attempt to use anatomically correct dolls for investigative purposes. Instead, a referral to DFCS or law enforcement should be made immediately. The mental health provider should attempt to reassure the child and prepare him/her for a possible forensic interview by a third party.

Any staff who receives information concerning child abuse or neglect is to report as follows:

- Therapists should report directly to the Department of Family and Children Services (DFCS) and notify their supervisor
- Clerical staff or other support staff should report the incident or information directly to supervisory staff
- Reports are to be made by phone with a written follow-up if requested by DFCS

The report should be made immediately. An immediate response from DFCS is required prior to the child's departure if danger of further abuse and neglect is suspected.

Information necessary for agency's investigation of the abuse or neglect is to be shared.

INVESTIGATIVE PROCEDURES

DEPARTMENT OF FAMILY & CHILDREN'S SERVICES

{Address and Phone Number-including after hours phone number}

A. Investigation of Accepted Reports:

- Reports of physical abuse and sexual abuse are reported by telephone by case manager to law enforcement. A joint decision is made as to law enforcement's involvement in the initial contact. If law enforcement does not participate in the initial contact, DFCS notifies law enforcement if their assistance is needed based on additional information received after contact.
- Representatives from law enforcement will meet weekly with DFCS to discuss/review all reports.
- Severe physical and all sexual abuse will be referred to the Child Advocacy Center or other designated location. There will be a joint decision by DFCS/Law Enforcement about a preliminary interview based on the validity of the report and actual disclosure by the child.
- In other cases of reports of physical abuse, DFCS will make the initial contact. Law enforcement will be contacted immediately if marks/bruises are severe. In cases where medical treatment is indicated or the cause of injury cannot be determined, a medical opinion will be sought.
- Law enforcement will be contacted if needed for securing parental cooperation, access to child or protection of the child.

B. Interviewing Children at School:

- When planning to interview the child at school, the DFCS case manager may contact the school counselor prior to being on site for the interview. The counselor will be responsible for arranging the interview.
- DFCS case manager will notify parents as soon as possible of the interview.

C. Investigative Reports:

- In reports where maltreatment has been indicated and the risk to the child is low, moderate or high, the CPS case manager may develop a safety plan to reduce the risk to the child in the least restrictive way possible. The plan must be agreed to and signed by the caretaker. If caretaker does not agree, law enforcement or Juvenile Court assistance may be requested for protection. (Law enforcement, protective custody or Juvenile Court Instant Order will be requested in cases of imminent danger. If no imminent danger, a petition for deprivation will be filed with Juvenile Court.)

- Cases determined to be low-risk will be closed and case manager will refer the family to community resources.
- Cases determined to be moderate to high risk where a safety plan is signed and agreed to by caregiver, will be opened for services. DFCS will provide on-going child protective services. If caretaker later refuses to follow plan and risk to child increases, law enforcement and/or Juvenile Court assistance may be sought.
- In all cases of sexual abuse with non-believing and/or non-cooperating non-offending parents, DFCS will file a petition in Juvenile Court for protection/cooperation and/or custody.
- When the case has been accepted by the DFCS/SIU, protocol for DFCS will be followed.

INVESTIGATIONS INVOLVING SUBSTANCE ABUSING MOTHERS AND NEWBORN INFANTS

The committee members recognize that infants born to substance abusing mothers is a growing problem in our community and that the children are at high risk of abuse or neglect, therefore the response and intervention in these cases should include the following:

- When a report is received by DFCS from a medical facility indicating that a mother has given birth and either the mother or infant has tested positive for an illegal substance and/or alcohol, DFCS will accept and assign the referral for an immediate to 24 hour response.
- DFCS will notify the appropriate law enforcement agency of the report and assess the need for a joint investigation.
- DFCS will communicate with the referral source (medical personnel/facility) that the investigation has been initiated. DFCS will then make a request for medical information/documentation concerning the following:
 - Current condition of the infant and mother
 - Written detail regarding the level and type of intoxicant in the mother and/or infant upon delivery
 - Anticipated date of discharge
 - Necessary medical follow-up that will be required for the care of the infant (e.g. heart or apnea monitors)
- DFCS will proceed to the medical facility to interview the parent and observe the infant, determine the level of extended family support which might reduce risk to the child, assess the mother's acceptance and responsibility for the situation and her willingness to accept treatment for substance abuse related problems. A referral to a prevention provider is needed for the newborn.
- In all cases involving substance-abusing mothers of newborns, DFCS will seek Court intervention to ensure the safety of the child. The staffing will determine which of the following actions will be pursued:
 1. An Ex Parte order or authorization for shelter care from the Juvenile Court granting DFCS immediate temporary custody;
 - or
 2. An immediate protective order mandating the mother complies with specific requirements to ensure for the safety of the child pending a formal hearing before the Juvenile Court.

LAW ENFORCEMENT

A. Basic Procedure for Police Investigation of Child Abuse

1. Law Enforcement should meet with complainant for nature of allegation.
2. Give immediate consideration to the child's safety and arrange for medical attention if needed.
3. Determine if the allegation of sexual abuse, physical abuse or neglect is founded by probable cause.
4. If the offense occurred outside of the responding officer's jurisdiction, advise complainant and assist with filing a report with the appropriate law enforcement agency.
5. Gather information for the incident report from complainant and any other adult witnesses with information.
6. If the responding officer has to interview the victim, officer should ask only basic non-detailed questions. A more detailed interview will be deferred to the investigator or trained interviewer (open ended questions—who, what, when, where and how).
7. Officers should then contact his/her supervisor so that they can notify an investigator.
8. Notify and assist DFCS if circumstances justify taking a child into protective custody.
9. Officer will complete the initial incident report.
10. Investigator should respond to and obtain evidence at the scene or medical facility. Observe, record, photograph, document and report events at the scene.
11. Obtain physical evidence from medical personnel if situation requires medical examination.
12. Consult with and document information gathered from hospital or school professionals at the scene (i.e., pediatrician, emergency room doctor, counselor, administrator, etc.).
13. Consult with other involved agencies and interview witnesses and parents of victim.
14. Obtain statements from victim by audio and/or video recordings through trained interviewer.
15. Arrange analysis and evaluation of evidence and review results with involved agencies.
16. Interview suspect when identified.
17. Obtain and execute any applicable search warrants for evidence to include known samples from victim, corroborating evidence from scene or other location.
18. Obtain arrest warrants, apprehend suspect and conduct additional interviews or interrogations within the issued rights of the suspect.
20. Compile case file for prosecution, criminal history check, etc.
21. Consult with District Attorney's office for prosecution.

22. Participate in subsequent judicial proceedings.

B. Law Enforcement Procedure for Joint Investigations

Joint investigation and cooperation between law enforcement and DFCS is vital to the goal of protecting the victim and preparing a solid court case. It is important to recognize that each report of child abuse brings with it its own set of circumstances, therefore making each report unique in some way. Law enforcement will refer to their own set of policies, consult with other agency policies and the law when presented with these obstacles.

Initial Response

- In cases where law enforcement receives the report of abuse, they will report the referral to DFCS.
- An initial screening of the referral should be conducted.
- Contact should be made with the reporter whenever possible to assess the accuracy of the referral, safety of the child and other issues that may influence the interview.
- Law enforcement will check their records for previous records or histories with the family.
- Law enforcement and DFCS will meet and discuss the case and decide how to proceed with the investigation.
- Law enforcement or DFCS will schedule and interview at the CAC or designated equipped location within 24 hours.
- If the interview does not take place within 24 hours, law enforcement will assist DFCS with protection of the victim if necessary.

SEXUAL ABUSE FORENSIC INTERVIEW PROCEDURE

*{Child Advocacy Center or designated location
Address and Phone Number}*

A. Joint Investigation

DFCS and law enforcement have committed to the joint investigation of child abuse cases, and to the coordination of the investigation of child sexual abuse, severe physical abuse cases, and other cases deemed necessary through the Child Advocacy Center or the designated location. Children who are alleged victims of sexual abuse or severe physical abuse will receive multidisciplinary response coordinated through the Child Advocacy Center or the designated location. Joint investigation shall include cross-reporting of allegations, collaborative interviewing, and interdisciplinary case review.

B. Forensic Interview Procedures

Forensic interviewing of alleged victims of child abuse is an extremely specialized skill, which requires research-informed knowledge and specialized training in specific areas. Some of these areas include:

- children's memory and suggestibility
- children as witnesses
- interviewing techniques
- child development
- use of anatomical dolls
- characteristics of abuse and neglect
- false allegations
- criminal codes
- effect of childhood trauma and stress
- recantation

The competence and objectivity of interviewers and the quality of the interview itself are frequently the focus of abuse investigations. **Trained interviewers should be utilized to conduct forensic sexual abuse interviews of children.** (*Opportunities for training are available. Please contact the Office of Child Advocate, Children's Advocacy Centers of Georgia, or the DFCS Special Investigations Unit for more training information*).

C. Child Advocacy Center (C.A.C.) {if applicable}

Interviews of children alleged to be victims of child sexual abuse should be conducted at the Child Advocacy Center. Sexual abuse forensic interviewing is a practice continually enhanced by emerging research. Personnel from law enforcement and DFCS should make every effort to follow C.A.C. procedures and to coordinate their investigative efforts in a manner which increases the efficiency of the investigation while minimizing additional trauma to the child. Include county C.A.C. protocol as an Appendix in the Child Abuse Protocol if applicable.

1. Services

All services by the Children's Advocacy Center are provided only upon referral from DFCS, law enforcement, and/or the district attorney's offices.

The Children's Advocacy Center provide the following services:

- Video and/or audio taped forensic interviews
- Coordination of multidisciplinary team (MDT) staffings
- Court testimony
- Court preparation

Additional services that may be provided are:

- Photo documentation of physical abuse
- Physical/sexual medical examinations by qualified personnel on a referral basis
- Forensic evaluations
- Individual therapy
- Group therapy
- Assessment and referrals
- Resource library materials
- Parent education/support groups
- Lectures, workshops, and other educational presentations

2. Making Referrals

Children who have made a disclosure regarding sexual abuse, or have medical evidence of abuse, or who exhibit behaviors suggestive of abuse should be referred for a joint forensic investigation of the abuse by DFCS and law enforcement (LE).

- Children 3 or under who are insufficiently verbal for an interview but who present with medical evidence or sexualized behaviors

should be referred by LE and/or DFCS for interdisciplinary review by contacting the Child Advocacy Center.

- Video recorded sexual abuse forensic interviews of children 3-17 should be conducted at the Child Advocacy Center, and will be scheduled at the request of DFCS or LE personnel only.
- Children 14-17 may be interviewed by a trained interviewer at an agency location if circumstances require immediate response; however, these cases should be referred to the Child Advocacy Center for interdisciplinary case coordination the following business day.
- Intake reports should be made to the Child Advocacy Center staff who will schedule an interview time. To ensure that all relevant information is obtained in the initial interview, all team members involved in the investigation should be present.

3. Forensic Interviews

Video/audio documentation of forensic interviews with child victims and/or child witnesses of abuse or homicide is available upon referral from appropriate agencies, including DFCS, law enforcement, the District Attorney's office, the Department of Juvenile Justice

- When videotaping, etc. is appropriate, the interview will be conducted at C.A.C by a qualified forensic interviewer.
- The assigned caseworker and law enforcement investigator assigned to the case will have access to observe the interview from a separate viewing room.
- Once videotaping has begun, taping should not be discontinued until the interview is completed.
- Two original videotapes, etc. will be recorded simultaneously. One original tape must remain secured in law enforcement custody. The second original tape will remain secured at the C.A.C.

4. Forensic Evaluations

Referrals may be made for children ages 3 to 17 when one or more of the following conditions are present and when participation in the evaluation will not compromise the best interests of the child:

- The child did not disclose abuse to investigators but there are other indicators strongly suggesting victimization, such as sexualized behaviors, medical evidence, statements of other children and/or witnesses, pornography, access by known offender, etc.
- The child did not disclose abuse to investigators but allegedly disclosed to some other person.

- Prosecution and/or child protective decisions cannot be made based on initial forensic interview results.

5. Multi Disciplinary Meetings (MDT)

The Children's Advocacy Center will coordinate multidisciplinary team (MDT) meetings for the primary purpose of facilitating communication between agencies involved in the investigation and prosecution of allegations of child abuse as well as those agencies responsible for protecting child victims. MDT staffings will provide agency members with a forum to discuss complex cases with other professionals, and as a result, will enhance both the decision-making and intervention processes.

- Requests for cases to be staffed by the MDT are accepted from any MDT member and/or appropriate agencies. Appropriate referral sources include, but are not limited to, DFCS, Board of Education, law enforcement, district attorney's office, the Department of Juvenile Justice, and medical and mental health personnel.
- MDT members may request to staff any case they believe can benefit from the collaborative input of the team. Requests can include cases involving children who were not seen for services at the C.A.C.
- MDT meetings will be held at a location decided by the protocol members, and an agenda identifying cases to be staffed at each meeting will be provided to all involved agencies at least 48 hours prior to the scheduled weekly meeting time.
- Because the purpose of the MDT staffing is to facilitate the sharing of information between agencies, all individuals from DFCS, law enforcement, prosecution, medical, and mental health that are involved with a case being staffed should be present.

All agencies will cooperate fully in sharing information with each other concerning the abuse allegation, the child, and any other persons involved in the incident in order to fulfill their respective duties. The agencies will assist each other in making the child available for interviewing if necessary to fulfill their duties and will inform each other immediately upon learning of a change of location, address, or phone number of the child.

JUDICIAL PROCEDURES

JUVENILE COURT PROCEEDINGS

Intake Decisions applicable to Juvenile Court Staff:

Make certain that seven days a week, twenty-four hours a day, including holidays and weekends, an individual will be authorized to provide child pickups.

- When making intake decisions, staff shall authorize placement in shelter care by completing the form entitled, "Authorization for Shelter Care".
- Three factors shall be considered in the authorization decision making process:
 1. there should be sufficient information to believe that the child is in immediate danger and removal from the home is necessary to protect the child;
 2. a review of the resources available which could prevent shelter care; and
 3. placement should be in the least restrictive, most family-like setting consistent with the best interest and needs of the child.
- Upon authorizing shelter care, the authorization form shall be faxed to DFCS on the next business day.
- If the intake officer is called by the police and informed of possible abuse, the police shall be advised to contact the DFCS worker who is on call.

Court Operations and Scheduling:

{Each county should specify how scheduling and court proceedings should be maintained}

- Scheduling of Cases: Every effort should be made to schedule cases involving child abuse as soon as possible and must be set within the time limitations set by law.
- Operations: Whenever it appears that DFCS should be involved in any hearing before the Court, the clerk shall call in advance and request the presence of a DFCS worker.
- A Guardian ad litem shall be appointed for every child abuse case. Such appointment should occur by the detention hearing.
- A detention hearing will be held within 72 hours to determine whether continued shelter care is required.
- Detention hearings are normally scheduled within 48 hours to be heard in 72 hours of a child's removal and placement in emergency foster care.
- SAAG's will be involved in all judicial proceedings.
- The adjudicatory hearing will be set no later than ten days after the filing of the petition or 30 days if the child is not detained.
- DFCS will be responsible for preparing and presenting the evidence necessary to prove deprivation exists.
- DFCS will take action required to have hearing scheduled.

- When appropriate, the court will issue a protective order to restrain a person from having contact with a child if that contact may be detrimental to the child.
- If it is the recommendation of the DFCS case manager that the child remain in foster care pending formal adjudication, and the court rules in favor of this, the Special Assistant Attorney General (SAAG) representing DFCS will ensure that a proper petition is filed by DFCS.
- In the rare event that scheduling/ filing deadlines are missed, the parties are aware that the department may reinstate the case by obtaining a new emergency pick up order.
- In preparation for court, caseworkers should contact the SAAG representing DFCS prior to the stated hearing.
- A child may not be placed with a parent/ custodian from whom he/she was removed without permission from the court.

Continuance

- In abuse cases the court should be reluctant to grant continuances, and should only do so, in its discretion, for providential, good or legal cause.
- Any continuance granted should be for the shortest period of time possible so that the case can reach an early resolution.
- Continuances should always be granted when in the best interest of the child.

{County should outline subpoenas procedures}

{County should include procedures for DFCS to notify foster/adoptive parent of change of custody}

COURT APPOINTED SPECIAL ADVOCATE (CASA)
{If Applicable}

A. CASA Responsibilities:

_____ County CASA is organized under the auspices of _____. The _____ County CASA Program provides screened, trained and supervised volunteers to advocate for the best interest of children involved in Juvenile Court Deprivation proceedings. The Judge appoints a CASA. A CASA is an officer of the Court. The role of the CASA is to provide the Court with independent and objective information regarding the status of the children involved in deprivation cases. _____ County CASA has its own professional coordinator. _____ County CASA handles neglect and physical abuse cases only.

B. Pre-dispositional Responsibilities:

- The purpose and focus of CASA assessment is to enable the CASA to inform the Court of the child's emotional status regarding participation in court proceedings and placement considerations.
- The CASA volunteer shall not interview the child concerning facts relating to allegations of abuse.
- The CASA shall not conduct in-depth investigation of allegations of abuse.
- Any information concerning such issues obtained in the CASA assessment shall be turned over to the DFCS and the assigned Attorney Guardian Ad Litem.
- The CASA's responsibilities are to make recommendations to the Court regarding adjudicatory or dispositional decisions that are within the Court's purview.

C. Post-dispositional Responsibilities:

- Advocate and keep focus on the child and the sense of urgency.
- Participate in case plan and interagency meetings.
- Monitor Court Orders; participate in reviews and all court hearings.
- Maintain contact with all parties involved in the case.
- Facilitate access to resources as related to court-ordered plan.
- Request court reviews if pertinent information must be shared.
- Negotiate, facilitate and advocate for the best interest of the child.

D. Confidentiality

- A CASA maintains strict confidentiality of all information related to a case.

- When appointed by court order, the CASA has the responsibility to interview all persons having knowledge of the child's situation and to review documents and reports relating to the child and family.
- The reproduction and distribution of confidential and personal information related to any child or family should be limited.
- Documents and reports contained in the records of an agency or institution should be reviewed by appointment in the office of the agency.
- Documents or reports required as evidence during the adjudicatory hearing would require a subpoena if not already being submitted by the petitioner or another party to the case.
- All information and records acquired or reviewed by a CASA can be disclosed only to the court or upon court order to a party to the case.

MAGISTRATE COURT PROCEDURES

This court shall be involved primarily in child abuse cases through the issuance of criminal warrants, against perpetrators, the holding of probable cause hearings, and setting bond and/or conditions of bail.

- When an individual seeks to secure a warrant for any type of child abuse, the magistrate shall inquire as to the whereabouts of the child and ensure his/her safety is protected.
- The magistrate shall then notify the appropriate police agency for investigation and further proceedings.
- Setting of bonds in child abuse cases shall be the responsibility of the Magistrate or Superior Court Judge as provided by law.
- It is unnecessary for a child abuse victim to appear at probable cause hearings. Evidence of such abuse at a preliminary or bond hearing shall be by alternate means, which are consistent with the Uniform Magistrate Court Rules.
- As a consideration of bail, the Magistrate should consider all the circumstances of the case paying particular attention to the safety of the child, including separating the abuser and child.

Should conditions of bail be imposed other than a mere monetary bond, those conditions should be made known to DFCS and the Juvenile Court. This should reduce any conflicts between the Courts and DFCS.

SUPERIOR COURT PROCEDURES

In Superior court during the trial of criminal charges against a defendant in child abuse case, the judge has particular responsibility to ensure a fair and judicious process for all parties including the victim. Outlined below are concerns requiring paramount consideration.

- Judges should ensure that the child is protected during the trial by conducting proceedings in a manner both protective of the child and absent of perpetrator intimidation, consistent with the defendant's Constitutional rights.
- Judges should ensure that these cases are given first priority on the trial calendar behind demand for trial and incarcerated defendants.
- Continuances should not be given except on legal grounds and the case should be rescheduled as promptly as possible. Every effort should be made to complete the trial within ninety (90) days of the arrest. Every effort should be made to accommodate the witnesses contributing their time.
- Sentencing should reflect the need to protect the victim from the perpetrator and be consistent with the family case plan enacted in Juvenile Court. To this end, communication with the Juvenile Court should be maintained prior to sentencing to ensure a consistent approach in handling the family situation.

Any plea-bargaining for a probationary sentence should be closely scrutinized by the Court and approved only after consultation with Juvenile Court, DFCS, law enforcement and mental health.

The primary concern of this protocol as it pertains to proceedings in the Superior Court relates to the role of the victim and the family in the prosecution of the perpetrator. The following events warrant child abuse investigations by the District Attorney's Office:

- All cases are assigned to an Assistant District Attorney to determine whether sufficient evidence exists to indict the alleged perpetrator.
- The Victim Assistance Coordinator will notify DFCS and/or the non-abusing parent of services available to the child of any hearings, etc. and set throughout the criminal justice process.
- Cases will be presented to a Grand Jury unless the alleged perpetrator pleads guilty prior to the Grand Jury proceedings. If indicted, a trial or a guilty plea should conclude the case.

At a trial, if the verbal testimony of the child is to be required, a private room should be made available to the child to prevent contact with the perpetrator prior to the child's testimony.

VICTIM PROTECTION

Magistrate and Superior Courts

- When issuing a warrant for any type of child abuse, the Magistrate will seek to ensure the safety of the child is protected.
- Setting of bonds in child abuse cases shall be the responsibility of the Magistrate or Superior Court Judge as provided by law.
- As a consideration of bail, the Magistrate or Superior Court Judge should consider all the circumstances of the case paying particular attention to the safety of the child.
- The Judge hearing the bond motion should impose certain restrictive conditions of bail other than a mere monetary bond, including but not limited to an order to have no contact with the child victim or any other child while out on bond and prior to finalization of the case.
- All such conditions of bail should be communicated to DFCS and the Juvenile Court.

Juvenile Court

Post-Adjudicatory Hearing Protective Orders:

The Juvenile Court may enter a protective order pursuant to O.C.G.A. § 15-11-57 and the order, among other possibilities, may do the following:

- Restrain or otherwise control the conduct of any person in relationship to the child.
- Require appropriate persons to refrain from or take actions, including staying away from the home of the child or participating in counseling or treatment.

The Juvenile Court should consider such an order if the child abuse case has been or is about to be disposed of, and after the person against whom the protective order is sought has had due process, notice and opportunity to be heard.

If the protective order is not considered at the Disposition Hearing, where appropriate, DFCS, through its counsel, should apply for a protective order. DFCS Counsel should request a hearing within ten days after the filing of the application for a protective order.

TREATMENT

TREATMENT FORMAT FOR CHILD ABUSE CASES

- A. For sexual and physical abuse cases staffed by the MDT, the MDT will assist the provider to determine if there is a need of referral for treatment, further screening or an extended evaluation. The MDT will identify the primary involved agency, which will make appropriate referrals for services and assure follow-up of these services. If an extended evaluation is indicated, the evaluation will be arranged by the appropriate agency identified by the MDT.
- B. If a treatment referral is indicated, the primary involved agency will provide the family with a list of local mental health providers known to have experience and expertise with child sexual and/or physical abuse. The Child Advocacy Center or designated location's staff will provide additional assistance in selecting a provider based on the needs of the child, the financial resources of the family, and the availability of the provider.
- C. The referring agency will facilitate the acquisition of pertinent information regarding the case for the mental health provider treating the child. If, after beginning treatment, the family refuses further treatment or becomes uncooperative, or the mental health provider thinks that this lack of cooperation is endangering the child, a referral to DFCS will be made as with any case involving mandatory reporting.
- D. Referrals for perpetrator treatment will be coordinated by Adult Probation and Parole for Superior Court cases, and the Department of Juvenile Justice for Juvenile Court cases.

Reporting Child Sexual Abuse when a Child Discloses During Therapy

If a child discloses sexual abuse or severe physical abuse during psychotherapy or counseling, the mental health provider should NOT attempt a forensic interview. The provider should not attempt to question the child in detail about the alleged abuse or attempt to use anatomically correct dolls for investigative purposes. Instead, a referral to DFCS or law enforcement should be made immediately. The mental health provider should attempt to reassure the child and prepare them for a possible forensic interview by a third party.

TRAINING

TRAINING

All mandated members agree to participate in on-going training related to the identification and intervention of child abuse. Such training equips members with skills needed to appropriately respond to child abuse allegations and determine needed prevention efforts. Some considerations would include the following indicators and risk factors of Abuse/Neglect:

Neglect and Maltreatment

- A. Child
 - 1. Physical indicators:
 - a) Chronic hunger or tiredness
 - b) Chronic health problems (i.e., skin, respiratory, digestive)
 - c) Medical problems left unattended
 - d) Inadequate hygiene (i.e., dirty and unwashed)
 - e) Developmentally delayed (i.e., speech disorder, failure to thrive)
 - f) Has been abandoned
 - g) Without adult supervision for extended periods of time
 - 2. Behavioral indicators:
 - a) Begging or stealing food
 - b) Chronic fatigue (i.e., falling asleep in school, dull/apathetic appearance, listlessness)
 - c) Poor school attendance or chronic lateness
 - d) Coming to school early and leaving late
 - e) Functions below grade/aptitude level in school
 - f) Delinquent/antisocial/destructive behavior (i.e., vandalism, inappropriate affection seeking, sucking/biting/rocking)
 - g) Use of drugs/alcohol
- B. Parent/Caretaker
 - 1. Behavioral Risk Factors
 - a) Apathetic
 - b) Craving for excitement/change
 - c) Desire to be rid of the demands of the child (i.e., isolates child for long periods of time, not listening or talking to child, leaves child alone or unattended)
 - d) Lack of interest in child's activities (i.e., fails to provide supervision and guidance, severely criticizes child, name-calling, scaring, lack of affection)
 - e) Lack of cooperation with agency

2. Environmental Risk Factors
 - a) Lack of parenting skills
 - b) Financial pressures
 - c) Marital problems
 - d) Inconsistent employment
 - e) Mental health problems
 - f) Drug/alcohol abuse
 - g) Long term illness
 - h) Chaotic family life
 - i) Neglected as a child
 - j) Poverty (i.e., low income, poor housing, isolation, large family)

Physical Abuse

Physical abuse may be suspected if the injuries listed below are not associated with accidental injuries or if the explanation does not fit the pattern of the injury.

A. Child

1. Physical indicators:
 - a) Bruises (i.e., occurring in unusual patterns; occurring on posterior side of body; occurring in clusters; occurring on an infant, especially on the face; in various stages of healing)
 - b) Burns (i.e., immersion burns, cigarette-type burns, restraint burns, appliance related burns etc.)
 - c) Unexpected missing or loosened teeth
 - d) Unexplained lacerations and abrasions
 - e) Inflicted marks (i.e., human bite marks, choke marks)
 - f) Skeletal injuries
 - g) Head injuries (i.e., absence of hair, nasal or jaw fractures, sub-dural hematomas, other more serious injuries)
 - h) Internal injuries
2. Behavioral indicators:
 - a) Wary of adults
 - b) Extreme behaviors (i.e., aggressive or withdrawn, frightened of sudden movements, apprehensive when other children cry)
 - c) Reports injuries by parents (i.e., frightened of parents, afraid to go home)
 - d) Wear long sleeves or other concealing clothing
 - e) Child's explanation of injury is inconsistent with nature of injury
 - f) Aggressive behavior to other children/animals
 - g) Indiscriminately seeks affection

- B. Parent/Caretaker
 - 1. Behavioral Risk Factors
 - a) Unrealistic expectations of child
 - b) Uses discipline which is inappropriate or extreme for child's age or behavior
 - c) Discipline is often cruel
 - d) Failed appointments (i.e., lack of cooperation with agency regarding child's health/injuries, reluctant to share information about child)
 - e) Discourages social contacts
 - f) Uses different medical facilities (i.e., refuses consent for medical exam/diagnostic testing)
 - g) Fails to obtain medical care for child
 - h) Believes in/defends corporal punishment
 - i) Religious practices that pose the risk of child abuse
 - j) Parent cannot be located
 - k) Parent conceals child's injuries
 - l) Parent confines child for extended periods of time
 - 2. Environmental Risk Factors
 - a) Parental history of child abuse
 - b) Lack of parenting skills
 - c) Marital problems
 - d) Mental/physical illness
 - e) Drug/alcohol problems
 - f) Social isolation
 - g) Financial pressures
 - h) Unemployment
 - i) Inadequate housing
 - j) Target child in home (i.e., physically or emotionally handicapped, developmentally disabled, unwanted)

Pediatric Condition Falsification

(Munchausen syndrome by proxy)

Pediatric Condition Falsification is a form of medical abuse initiated by a caregiver. It consists of chronic false reporting of symptoms and/or inducement of illness. The child is then unnecessarily exposed to medical interventions. The primary reason for this falsification of signs or symptoms in the child/victim by the perpetrator is called Factitious Disorder by Proxy. This is a psychiatric concept in which the adults seek attention at another's expense, and have the ability not only to lie but to imposture. An older term, Munchausen syndrome by proxy, refers to Pediatric Condition Falsification in which Factitious Disorder by Proxy is also present. In some instances, the non-perpetrating spouse or others help maintain the deceptive process by their failure to believe the doctors, blindly support the perpetrator, and/or at times actively collude with the deception.

A. Child – presentations

1. Physical condition
 - a) Perpetrator directly inducing conditions (examples—vomiting or diarrhea induced by drug administration, causing apnea by occluding the airway)
 - b) Perpetrator deceptively reports signs and symptoms thereby misrepresenting the victim as ill (examples—reporting seizure activity, symptoms reported but child appears healthy—such as high fevers).
 - c) Perpetrator presents false evidence of illness (examples—blood placed in victim’s bodily fluids)
2. Psychological condition
 - a) Perpetrator reports false psychological symptoms (examples—excessive anxiety, school refusal, stress reactions, schizophrenia)
3. Sexual Abuse
 - a) Perpetrator repeatedly requests evaluation for false allegations of sexual abuse. This is Pediatric Condition Falsification although there is some dispute whether all cases are also Factitious Disorder by Proxy.

B. Parent/Caretaker – characteristics

- 1) Goal is to gain attention for themselves
- 2) Masquerade as the “good mother”
- 3) Occasionally use the child to gain material goods

C. Colluding family members – possibilities

- 1) Passive spouse
- 2) Abusive spouse
- 3) Help maintain deception by defending the perpetrator

D. Others

- 1) Doctors may be found who are more easily fooled and help to continue the deception
- 2) “Doctor shopping” may occur to hide the deceptions (e.g. obtaining multiple medications) or to avoid a doctor getting wise to the situation
- 3) Lawyers and judges may have problems recognizing this form of abuse as serious and propose plans that do not adequately protect the child’s physical and emotional health

E. Outcomes

- 1) Up to 10% death rate in the literature – may be 2-5% in actuality
- 2) Apparently all children will be emotionally damaged if returned home to the perpetrator
- 3) No plan for the perpetrator seems to work

Sexual Abuse

A. Child

1. Physical indicators:

- a) Difficulty in walking or sitting
- b) Complaints of pain or discomfort in genital area
- c) Torn/stained/bloody underclothing
- d) Unusual or offensive odors
- e) Poor sphincter control in previously toilet trained child
- f) Self-Mutilation, disfigurement
- g) Medical indicators (i.e., bruises/bleeding/laceration in genitalia or anus; genital or rectal pain, itching, or swelling; venereal disease; discharge; pregnancy; extreme passivity in a pelvic exam)

2. Behavioral indicators:

- a) Sophisticated or unusual sexual knowledge and/or behavior (i.e., preoccupation with sexual organs of self/parent/other children, seductive behavior, sexual promiscuity, excessive masturbatory behavior, poor physical boundaries, perpetration to other children)
- b) Wearing many layers of clothing, regardless of weather
- c) Reluctance to go to a particular place or to be with a particular person
- d) Recurrent nightmares or disturbed sleep patterns and fear of dark
- e) Withdrawal/fantasy
- f) Infantile behavior
- g) Overly affectionate/indiscriminately seeks affection

B. Parent/Caretaker

1. Risk Factors

- a) Marked role reversal between mother and child
- b) Extreme over protectiveness of the child
- c) Isolation of child from peer contact and community systems
- d) Domineering/rigid disciplinarian
- e) History of sexual abuse for either parent
- f) Extreme reaction to sex education or prevention education in the schools
- g) Physical and/or psychological unavailability of mother
- h) Marital dysfunction

- i) Presence of unrelated male in the home

Emotional/ Verbal Abuse

A. Child

1. Physical indicators:

- a) Regressive habits, such as rocking, or thumb sucking in an older child
- b) Poor peer relations
- c) Daytime anxiety and unrealistic fears
- d) Behavioral extremes: either aggressive/antisocial or passive/withdrawn
- e) Problems sleeping at night, may fall asleep during day
- f) Speech disorders
- g) Learning difficulties
- h) Displays low self-confidence/self-esteem
- i) Sadomasochistic behavior (displays cruelty towards other children or animals, or seems to derive satisfaction from being mistreated)
- j) Lack of concern for personal safety, oblivious to hazards and risks

B. Parent/Caretaker

1. Behavioral Risk Factors

- a) Unrealistic expectations of child
- b) Uses extreme discipline, overreacts when child misbehaves or does not meet parents expectations
- c) Consistently displays ridicule and shame towards child
- d) Does not reward, praise or acknowledge child's positive qualities or achievements
- e) Blames and punishes child for things over which the child has no control
- f) May use bizarre and inappropriate forms of punishment, such as isolating a child in a closet or humiliating a child in public
- g) Threatens the child with abandonment or placement in an institution

2. Environmental Risk Factors

- a) Parents were victims of some form of child abuse: physical, sexual, emotional
- b) Marital problems
- c) Isolated, no support system
- d) Low self-esteem
- e) Drug/alcohol problems
- f) Does not understand normal developmental stages of children
- g) Mentally/physically ill
- h) Financial/employment problems

- i) Child unwanted
- j) Family violence

All training designed to help professionals deal appropriately with children who have suffered abuse should include information found below. Professionals working with children are often unsure of the appropriate response to children who have been abused. Try to normalize the situation by acknowledging it as you would divorce, death, or other traumatic crises in a child's life. Try not to dwell on the abuse or ignore inappropriate behavior. Your role is to help build the child's self-esteem and sense of safety and security. Some suggestions are:

- A. Maintain contact with the child's caseworker, therapist, and non-offending parent when appropriate.
- B. Be aware of such events as foster care placement and juvenile/criminal court proceeding.
- C. Be sensitive to touching the sexually abused child without asking permission.
- D. Do not tolerate inappropriate sexual or violent behavior. Reassure the child that he/she is OK, but that the behavior is unacceptable.
- E. If the child wants to talk more about the abuse, find a private place to listen, validate feelings, and continue to be supportive.
- F. Respect the family's feelings and need for privacy. Do not discuss the abuse with persons not involved.
- G. Abused children especially need to hear self-esteem messages such as: "You are healthy", "You have every right to be here", "You have every right to be safe" or "You are brave for telling".
- H. Recognize your need for support in dealing with your own feelings of pain, fear, anger, and powerlessness.

PREVENTION

PREVENTION

The goals of prevention in the Child Abuse Protocol include the tracking of statistical information relating to child abuse cases, the utilization of data to determine needed community prevention and treatment services, and a description of methods that have been implemented to prevent child abuse.

Prevention and treatment services listed below promote the general welfare of children and families, provide prevention activities to children, families and the community and provide prevention of the recurrence of abuse and neglect.

{ *Delete or add as resources are available.* }

_____ County has:

- an umbrella agency which plans, coordinates, and evaluates needed children and family programs and services - **NAME OF ORGANIZATION (s)**
- hospital-based social service workers - **NAME OF ORGANIZATION (s)**
- home health nurse- **NAME OF ORGANIZATION (s)**
- hospital-based prevention visits for all new parents - **NAME OF ORGANIZATION (s)**
- improved access to health care- **NAME OF ORGANIZATION (s)**
- parent education programs- **NAME OF ORGANIZATION (s)**
- pre-kindergarten programming - **NAME OF ORGANIZATION (s)**
- after-school and summer programming - **NAME OF ORGANIZATION (s)**
- a system of identification of "at-risk" teen families and home-based prevention and services- **NAME OF ORGANIZATION (s)**
- hospital-based referrals to community-based agencies for services - **NAME OF ORGANIZATION (s)**
- a shelter for battered women - **NAME OF ORGANIZATION (s)**
- a shelter for children and youth - **NAME OF ORGANIZATION (s)**
- an alternative learning school - **NAME OF ORGANIZATION (s)**
- school-based mental health counseling - **NAME OF ORGANIZATION (s)**
- a "Drug Elimination Program" - **NAME OF ORGANIZATION (s)**
- prevention education & counseling - **NAME OF ORGANIZATION (s)**
- community awareness information and events program - **NAME OF ORGANIZATION (s)**
- a rape prevention education & crisis line - **NAME OF ORGANIZATION (s)**
- a child-friendly interview room - **NAME OF ORGANIZATION (s)**
- parenting support assigned by CPS through DFCS - **NAME OF ORGANIZATION (s)**

ENSURING COMPLIANCE

ENSURING COMPLIANCE

In order to ensure compliance, the child abuse protocol committee should:

- Meet at least quarterly to determine if the protocol is being followed.
- Conduct an annual review of all sections of the protocol and should amend or revise as necessary.

Participation

The following is a list of actions that will be initiated if a member of the Child Abuse Protocol Committee is routinely absent from committee meetings.

- The Chair or designee of the committee will contact the member directly via telephone, mail or in person and notify the member of his/her responsibility to attend the meetings. For those members mandated in O.C.G.A §19-5-2 (c)(1), the chair will remind them that the law mandates him/her to attend the meetings.
- Follow-up with a letter to the member referencing Step #1, and copy it to his/her supervisor within the agency.
- Contact the members' supervisor and follow-up with a letter. Copy and send this letter to the member.
- Continue to follow the chain of command within the agency and appeal to the state, director/co-director and/or division director of the agency.
- Submit copies, from chair of committee, of all correspondence to Georgia Child Fatality Review Panel, and a motion will be filed by the panel with the superior court judge to hold this person in contempt of court pursuant to O.C.G.A §19-15-2 (3).

Annual Report

1. The Annual Report should evaluate the following:
 - the extent to which child abuse investigations within the county have complied with the protocol
 - recommendations to improve compliance
 - measures taken within the county to prevent child abuse that have been successful
2. The Annual report will be provided to the following:
 - the county governing authority
 - the fall term Grand Jury of the judicial circuit
 - the chief superior court judge
 - the Georgia Child Fatality Review Panel
3. The Annual Report is due by **July 1st** of each year.

APPENDIX A

LEGAL REQUIREMENT TO REPORT CHILD ABUSE

LEGAL REQUIREMENT TO REPORT CHILD ABUSE

A. The purpose of this Code section is to provide for the protection of children whose health and welfare are adversely affected and further threatened by the conduct of those responsible for their care and protection. It is intended that the mandatory reporting of such cases will cause the protective services of the state to be brought to bear on the situation in an effort to prevent further abuses, to protect and enhance the welfare of these children, and to preserve family life wherever possible. This Code section shall be liberally construed so as to carry out the purposes thereof.

B. O.C.G.A §19-15-1 Definitions

As used in this chapter, the term:

(1) 'Abused' means subjected to child abuse.

(2) 'Child' means any person under 18 years of age.

(3) 'Child abuse' means:

(A) Physical injury or death inflicted upon a child by a parent or caretaker thereof by other than accidental means; provided, however, physical forms of discipline may be used as long as there is no physical injury to the child;

(B) Neglect or exploitation of a child by a parent or caretaker thereof;

(C) Sexual abuse of a child; or

(D) Sexual exploitation of a child.

(4) 'Child protection professional' means any person who is employed by the state or a political subdivision of the state as a law enforcement officer, school teacher, school administrator, or school counselor or who is employed to render services to children by the Department of Human Resources or any county board of health or county department of family and children services.

(5) 'Eligible deaths' means deaths meeting the criteria for review by a county child fatality review committee including deaths resulting from Sudden Infant Death Syndrome, unintentional injuries, intentional injuries, medical conditions when unexpected or when unattended by a physician, or any manner that is suspicious or unusual.

(6) 'Investigation' in the context of child death includes all of the following:

(A) A post-mortem examination which may be limited to an external examination or may include an autopsy;

(B) An inquiry by law enforcement agencies having jurisdiction into the circumstances of the death, including a scene investigation and interview with the child's parents, guardian, or caretaker and the person who reported the child's death;

(C) A review of information regarding the child and family from relevant agencies, professionals, and providers of medical care.

(7) 'Panel' means the Georgia Child Fatality Review Panel established pursuant to Code Section 19-15-4. The panel oversees the local child fatality review process and reports to the Governor on the incidence of child deaths with recommendations for prevention.

(8) 'Protocol committee' means a multidisciplinary, multiagency child abuse protocol committee established for a county pursuant to Code Section 19-15-2.

The protocol committee is charged with developing local protocols to investigate and prosecute alleged cases of child abuse.

(9) 'Report' means a standardized form designated by the panel, which is required for collecting data on child fatalities reviewed by local child fatality review committees.

(10) 'Review committee' means a multidisciplinary, multiagency child fatality review committee established for a county or circuit pursuant to Code Section 19-15-3. The review committee is charged with reviewing all eligible child deaths to determine manner and cause of death and if the death was preventable.

(11) 'Sexual abuse' means a person's employing, using, persuading, inducing, enticing, or coercing any minor who is not that person's spouse to engage in any act which involves:

(A) Sexual intercourse, including genital-genital, oral-genital, anal-genital, or oral-anal, whether between persons of the same or opposite sex;

(B) Bestiality;

(C) Masturbation;

(D) Lewd exhibition of the genitals or pubic area of any person;

(E) Flagellation or torture by or upon a person who is nude;

(F) Condition of being fettered, bound, or otherwise physically restrained on the part of a person who is nude;

(G) Physical contact in an act of apparent sexual stimulation or gratification with any person's clothed or unclothed genitals, pubic area, or buttocks or with a female's clothed or unclothed breasts;

(H) Defecation or urination for the purpose of sexual stimulation; or

(I) Penetration of the vagina or rectum by any object except when done as part of a recognized medical procedure.

'Sexual abuse' shall not include consensual sex acts involving persons of the opposite sex when the sex acts are between minors or between a minor and an adult who is not more than three years older than the minor. This provision shall not be deemed or construed to repeal any law concerning the age or capacity to consent.

(12) 'Sexual exploitation' means conduct by a child's parent or caretaker who allows, permits, encourages, or requires that child to engage in:

(A) Prostitution, as defined in Code Section 16-6-9; or

(B) Sexually explicit conduct for the purpose of producing any visual or print medium depicting such conduct, as defined in Code Section 16-12-100.

APPENDIX B

CHILD FATALITY REVIEW (CFR)

CHILD FATALITY REVIEW

The unexpected death of a child creates a crisis for the family, friends, and community. In an attempt to reduce such tragedies, the Georgia Legislature mandated that each county establish a Child Fatality Review committee to review any sudden or unexplained death of a child under the age of 18. The Child Abuse Protocol committee will cooperate and work with the Child Fatality Review committee in investigations of all reviewable deaths.

O.C.G.A §19-15-3

(a)(1) Each county shall establish a local multidisciplinary, multiagency child fatality review committee as provided in this Code section. The chief superior court judge of the circuit in which the county is located shall establish a child fatality review committee composed of, but not limited to, the following members:

- (A) The county medical examiner or coroner;
- (B) The district attorney or his or her designee;
- (C) A county department of family and children services representative;
- (D) A local law enforcement representative;
- (E) The sheriff or county police chief or his or her designee;
- (F) A juvenile court representative;
- (G) A county board of health representative; and
- (H) A county mental health representative.

(2) The district attorney or his or her designee shall serve as the chairperson to preside over all meetings.

(b) Review committee members shall recommend whether to establish a review committee for that county alone or establish a review committee with and for the counties within that judicial circuit.

(c) The chief superior court judge shall appoint persons to fill any vacancies on the review committee should the membership fail to do so.

(d) If any designated agency fails to carry out its duties relating to participation on the local review committee, the chief superior court judge of the circuit or any superior court judge who is a member of the Georgia Child Fatality Review Panel shall issue an order requiring the participation of such agency. Failure to comply with such order shall be cause for punishment as for contempt of court.

(e) Deaths eligible for review by local review committees are all deaths of children ages birth through 17 as a result of:

- (1) Sudden Infant Death Syndrome;
- (2) Any unexpected or unexplained conditions;
- (3) Unintentional injuries;
- (4) Intentional injuries;
- (5) Sudden death when the child is in apparent good health;
- (6) Any manner that is suspicious or unusual;
- (7) Medical conditions when unattended by a physician. For the purpose of this paragraph, no person shall be deemed to have died unattended when the death occurred while the person was a patient of a hospice licensed under Article 9 of Chapter 7 of Title 31; or
- (8) Serving as an inmate of a state hospital or a state, county, or city penal

institution.

(f) It shall be the duty of any law enforcement officer, medical personnel, or other person having knowledge of the death of a child to immediately notify the coroner or medical examiner of the county wherein the body is found or death occurs.

(g) If the death of a child occurs outside the child's county of residence, it shall be the duty of the medical examiner or coroner in the county where the child died to notify the medical examiner or coroner in the county of the child's residence.

(h) When a county medical examiner or coroner receives a report regarding the death of any child he or she shall within 48 hours of the death notify the chairperson of the child fatality review committee of the county or circuit in which such child resided at the time of death.

(i) The coroner or county medical examiner shall review the findings regarding the cause and manner of death for each child death report received and respond as follows:

(1) If the death does not meet the criteria for review pursuant to subsection (e) of this Code section, the coroner or county medical examiner shall sign the form designated by the panel stating that the death does not meet the criteria for review. He or she shall forward the form and findings, within seven days of the child's death, to the chairperson of the child fatality review committee in the county or circuit of the child's residence; or

(2) If the death meets the criteria for review pursuant to subsection (e) of this Code section, the coroner or county medical examiner shall complete and sign the form designated by the panel stating the death meets the criteria for review. He or she shall forward the form and findings, within seven days of the child's death, to the chairperson of the child fatality review committee in the county or circuit of the child's residence.

(j) When the chairperson of a local child fatality review committee receives a report from the coroner or medical examiner regarding the death of a child, that chairperson shall review the report and findings regarding the cause and manner of the child's death and respond as follows:

(1) If the report indicates the child's death does not meet the criteria for review and the chairperson agrees with this decision, the chairperson shall sign the form designated by the panel stating that the death does not meet the criteria for review. He or she shall forward the form and findings to the panel within seven days of receipt;

(2) If the report indicates the child's death does not meet the criteria for review and the chairperson disagrees with this decision, the chairperson shall follow the procedures for deaths to be reviewed pursuant to subsection (k) of this Code section;

(3) If the report indicates the child's death meets the criteria for review and the chairperson disagrees with this decision, the chairperson shall sign the form designated by the panel stating that the death does not meet the criteria for review. The chairperson shall also attach an explanation for this decision; or

(4) If the report indicates the child's death meets the criteria for review and the

chairperson agrees with this decision, the chairperson shall follow the procedures for deaths to be reviewed pursuant to subsection (k) of this Code section.

(k) When a child death meets the criteria for review, the chairperson shall convene the review committee within 30 days after receipt of the report for a meeting to review and investigate the cause and circumstances of the death. Review committee members shall provide information as specified below, except where otherwise protected by statute:

(1) The providers of medical care and the medical examiner or coroner shall provide pertinent health and medical information regarding a child whose death is being reviewed by the local review committee;

(2) State, county, or local government agencies shall provide all of the following data on forms designated by the panel for reporting child fatalities:

(A) Birth information for children who died at less than one year of age including confidential information collected for medical and health use;

(B) Death information for children who have not reached their eighteenth birthday;

(C) Law enforcement investigative data, medical examiner or coroner investigative data, and parole and probation information and records;

(D) Medical care, including dental, mental, and prenatal health care; and

(E) Pertinent information from any social services agency that provided services to the child or family; and

(3) The review committee may obtain from any superior court judge of the county or circuit for which the review committee was created a subpoena to compel the production of documents or attendance of witnesses when that judge has made a finding that such documents or witnesses are necessary for the review committee review. However, this Code section shall not modify or impair the privileged communications as provided by law except as otherwise provided in Code Section 19-7-5.

(l) The review committee shall complete its review and prepare a report of the child death within 20 days, weekends and holidays excluded, following the first meeting held after receipt of the county medical examiner or coroner's report.

The review committee report shall:

(1) State the circumstances leading up to death and cause of death;

(2) Detail any agency involvement prior to death, including the beginning and ending dates and kinds of services delivered, the reasons for initial agency activity, and the reasons for any termination of agency activities;

(3) State whether any agency services had been delivered to the family or child prior to the circumstances leading to the child's death;

(4) State whether court intervention had ever been sought;

(5) State whether there have been any acts or reports of violence between past or present spouses, persons who are parents of the same child, parents and children, stepparents and stepchildren, foster parents and foster children, or other persons living or formerly living in the same household;

(6) Conclude whether services or agency activities delivered prior to death were appropriate and whether the child death could have been prevented;

(7) Make recommendations for possible prevention of future deaths of similar

incidents for children who are at risk for such deaths; and

(8) Include other findings as requested by the Georgia Child Fatality Review Panel.

(m) The review committee shall transmit a copy of its report within 15 days of completion to the panel.

(n) The review committee shall transmit a copy of its report within 15 days following its completion to the district attorney of the county or circuit for which the review committee was created if the report concluded that the child named therein died as a result of:

(1) Sudden Infant Death Syndrome when no autopsy was performed to confirm the diagnosis;

(2) Accidental death when it appears that the death could have been prevented through intervention or supervision;

(3) Any sexually transmitted disease;

(4) Medical causes which could have been prevented through intervention by an agency or by seeking medical treatment;

(5) Suicide of a child in custody or known to the Department of Human Resources or when the finding of suicide is suspicious;

(6) Suspected or confirmed child abuse;

(7) Trauma to the head or body; or

(8) Homicide.

(o) Each local review committee shall issue an annual report no later than the first day of July in 2001 and in each year thereafter. The report shall:

(1) Specify the numbers of reports received by that review committee from a county medical examiner or coroner pursuant to subsection (h) of this Code section for the preceding calendar year;

(2) Specify the number of reports of child fatality reviews prepared by the review committee during such period;

(3) Be published at least once annually in the legal organ of the county or counties for which the review committee was established with the expense of such publication paid each by such county; and

(4) Be transmitted, no later than the fifteenth day of July in 2001 and in each year thereafter, to the Georgia Child Fatality Review Panel and the Judiciary Committees of the House of Representatives and Senate.

APPENDIX C

EMERGENCY CUSTODY BY A PHYSICIAN

Emergency Custody by a Physician

Procedures

1. The desired procedure whenever abuse is suspected is to notify DFCS or Law Enforcement of the suspected abuse as outlined in the proceeding sections, however, in some circumstances events may be moving too fast to contact DFCS or Law Enforcement in order to protect a child who is being treated from "imminent danger"

The *elements* necessary for emergency custody to be taken by the physician are:

- **Abuse** is present- There should be a strong belief by the physician that abuse is present and/or will occur. Whereas child abuse reporting requires only a reasonable suspicion, taking emergency custody of a child should be based on a stronger belief by the physician.
 - **Imminent danger**- Some sort of emergency should exist, for example:
 - The abusing parents are attempting to remove the child against medical advice, or
 - Law enforcement refuses to assume custody and a court order is necessary but cannot be obtained timely.
 - **No time** for usual procedures to be followed before the child is removed. Events are moving too fast to contact anyone.
2. After a determination is made by the physician to take emergency custody, the physician should:
 - Ensure that there is sufficient security to avoid danger to staff.
 - Tell any persons with the child that you have assumed custody of the child pursuant to law; and take reasonable and diligent efforts to inform the parents, guardian or custodian of the child of the child's whereabouts.
 - Orally notify DFCS immediately and thereafter report in writing if requested.
 - Not later than 24 hours notify the Juvenile Court Intake officer (911 will assist in such notification.) who will determine, based on your information, whether the child shall be detained. Alternatively the physician may contact a law enforcement officer who shall take the child into custody and promptly bring the child before a juvenile court intake officer.
 - Document thoroughly what has been done and why.
 - If the intake officer determines that the child should not be detained, the child should be released immediately to the child's parents, guardian or custodian.

- If detention of the child is authorized, the physician should admit the child if medically necessary; if not medically necessary DFCS shall pick up the child within 6 hours.
- Be prepared to go to court and testify within 72 hours – the physician will be notified of the hearing time and day.
- The physician is given the obligation under the law to file the appropriate Deprivation Petition in the Juvenile Court within five days of the detention hearing. The physician should determine from DFCS if they intend to file a petition first and if they indicate that they will the physician obligation will be obviated. However, the physician should know that should this Petition not be filed the child must be released at the end of the five days to the parent.

Physician Liability

Any hospital or physician acting in good faith and in accordance with accepted medical practice in the treatment of the child shall have immunity from any liability, civil or criminal, that might be incurred or imposed as a result of taking or failing to take any action authorized herein.

X. SIGNATURE PAGE

The signature page should be attached and signed by all members. Members titles should also be given.

County District Attorney

County Coroner

***County Public Health Department
Representative***

***County Department of Family and
Children Services Representative***

County Sheriff Department

County Police Department

County Juvenile Court

County Magistrate Court

County Board of Education

County Mental Health